ANALYTICAL AND BIBLIOGRAPHICAL NOTICES.

Art. XVII.—*Medico-Chirurgical Transactions.* Published by the Royal Medical and Chirurgical Society of London. Volume the Fifty-sixth. 8vo. pp. lxviii., 492. London: Longmans, Green, Reader, & Dyer, 1873.

The present volume of this admirable series contains twenty-two papers, of which we shall, according to custom, offer our readers a short account, taking up first the surgical communications, and grouping together the medical papers for after-consideration.

The first article in the volume is *On Non-purulent Catarrh of the Middle Ear*, by William Bartlett Dalby, F.R.C.S., M.B. Cantab., etc. This is principally founded upon notes of cases treated by Mr. Dalby at St. George's Hospital, and abstracts of twenty, which the author looks upon as typical cases, are given in an appendix. The remedies chiefly employed appear to have been repeated inflations of the tympanum, either by Politzer's method or through the Eustachian catheter, and the introduction of warm solutions of bicarbonate of soda, muriate of ammonia, or iodide of potassium, or of iodine vapour, or simply warm water, sometimes by the catheter, but more commonly by a modification of the simple method known as Gruber's. Hinton's plan of incising the membrane, and washing out the cavity of the tympanum by injecting solutions from the meatus inwards, is regarded by Mr. Dalby as only serviceable in exceptional instances. From a review of all his cases the author concludes that in cases of obstruction of the Eustachian tube, when the tympana are not involved, recovery may be expected, as it may be likewise when catarrhal affections of the tympana are treated at an early stage. When, however, the secretion has become inspissated before the patient applies for relief, and only dry sounds are heard on inflation of the tympanum, there is, in most instances, but little prospect of a satisfactory result.

The second paper is a *Case of Ovarian Dropsy operated on during an attack of Acute Peritonitis*; by Richard T. Tracy, M.D., etc. An abstract of Dr. Tracy's paper appeared in the Quarterly Summary of this Journal for January, 1873, page 267.

A Fifth Series of One Hundred Cases, with Remarks on the Results of Five Hundred Cases of Ovariotomy, is contributed by T. Spencer Wells, F.R.C.S., etc. From his very large personal experience in ovariotomy, Mr. Wells draws, in this paper, certain important conclusions as to the various circumstances which exercise a favourable or an unfavourable influence on the results of the operation. Comparing his *hospital* with his *private* cases, he finds that the numbers are nearly equal, and that the mortality of the former has been 26.66 as against 24.23 per cent. of the latter, thus showing a difference of only 2.43 per cent. in favour of cases treated in private practice. For limited periods of time, however, the proportion has occasionally been very different, the mortality of hospital operations having been in one series of a hundred cases more than double that met with in private patients. In seeking for the causes of this variation:—

"It has become manifest that periods of high and low mortality have corresponded with varying sanitary conditions in the hospital, or with the presence of infecting cases in some ward. After emptying the house for a month or longer, thoroughly cleansing, painting, and lime-whiting the wards, a period of almost uninterrupted success has followed. Then what some call 'a run of bad luck' set in, attributable, I believe, to crowding, to some neglect in purifying bedding, or to contagion or infection. . . . . My conviction is, that the surgeon who hopes to obtain better results than have hitherto been obtained, must place his patient, whether in hospital or private practice, as nearly as he can in the position of a person in a private house—in a healthy situation, in a room where ventilation is sufficient and continual, but not excessive, and the temperature is under proper regulation; all unnecessary furniture (such as woollen carpets and curtains) removed; all bedding and clothing being perfectly clean and free from any taint of morbid poison; and the patient having the undivided attention of one trustworthy nurse for several days after operation."

The *season of the year* at which the operation is performed, and the *conjugal condition* of the patient, appear to exercise little or no influence on the result; whereas the *age* of the patient is a matter for serious consideration. Mr. Wells's statistics show that patients under 20, and those over 60 years of age, almost all recover after ovariotomy, while the highest rate of mortality (33 per cent.) is met with in those between 50 and 55. *Adhesions* to the abdominal parietes, or to the omentum, are found to be of not much importance, but adhesions within the pelvis add greatly to the risks of the operation. The *length of the incision*, as determined by the size, solidity, and weight of the tumour, exercises a marked influence on the result of the operation. When the abdominal wound has not exceeded five inches, the mortality in Mr. Wells's cases has been 21.66 per cent., as against 31.25 per cent. for wounds of six inches; 34.48 per cent. for those of seven inches; 35 per cent. for those of eight inches; 50 per cent. for those of nine inches; and 100 per cent. for incisions of still greater magnitude.

The *treatment of the pedicle* Mr. Wells expects to consider more fully upon another occasion, but he here mentions that his statistics show a mortality of 19.77 per cent. for cases in which the clamp has been employed, as compared with a death-rate of 32.65 per cent. for cases in which the extra-peritoneal method has been otherwise carried out; and of 38.63 per cent. for cases in which the intra-peritoneal method has been resorted to.

With his whole series of 500 cases of completed ovariotomy, Mr. Wells has had to report 52 cases of exploratory incision, or of uncompleted operation. In 19 of these cases death ensued in from one to fifteen days afterwards, while in the remaining 33 the patients were more or less benefited; and in 5 complete recovery was ultimately obtained. Mr. Wells terminates his paper with a calculation, after the manner of Dr. Peaslee, of the number of thousands of years which his operations have added to the aggregate life of the fairer portion of creation; an application of statistics, we must add, which has always impressed us as more ingenious than judicious.

The next paper is a *Case of Subclavian Aneurism, in which Temporary Compression of the Innominate was tried, followed by Ligature of that vessel;* by E. R. BICKERSTETH, F.R.C.S.E., etc. The patient was a dock porter, forty years of age, and the aneurism involved the third and part of the second portion of the right subclavian artery. Mr. Bickersteth employed a modification of Mr. Porter's "artery compressor"[1]—itself a modification of Sir Philip Crampton's "*presse-artère*"—introducing, however, India-rubber "accumulators," so as to obtain the benefits which accrue from the use of elastic pressure. This instrument was applied to the innominate artery; but on the morning of the third day the wire which compressed the vessel gave way, and pulsation immediately returned in the aneurism. The wound was thereupon opened, the compressor removed, and ligatures applied one on either side of the point of compression. Secondary hemorrhage began six days after this second operation, and recurred at intervals until the death of the patient twenty-five hours subsequently. A *post-mortem* examination showed that the innominate artery was occluded on the cardiac, but not on the distal side of the ligatures, while the sac of the aneurism was filled with laminated clot, and a clot also occupied, though it did not fill, the subclavian and axillary arteries beyond the position of the aneurism; the subclavian and innominate arteries between the aneurism and the ligature, and the carotid artery, were entirely empty. The fatal hemorrhage had proceeded from the distal side of the external ligature.

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[1] The "instrument not unlike a miniature lithotrite," which, by an odd mistake, Mr. Bickersteth describes as Mr. Porter's, is the invention of Dr. L'Estrange,

This case, studied in connection with Mr. Porter's, seems to us to show that acupressure and its modifications are ill-suited for the treatment of subclavian aneurism. In Mr. Porter's case the pressure caused sloughing of the artery, with consequent fatal hemorrhage, and in Mr. Bickersteth's case, though compression was maintained for forty-five hours, the aneurism pulsated as forcibly as ever the moment the pressure was removed. This case seems to us also to furnish a strong argument in favour of the mode of treatment suggested by Sir Wm. Fergusson, and happily put in practice by Prof. Spence, viz., amputation at the shoulder-joint as a modified distal operation: it will be observed that though, at the autopsy, the arteries between the aneurism and the ligatures were found empty, the aneurismal sac itself was filled with laminated clot, and the artery on its distal side was nearly, though not quite, occluded; now is it not obvious that if, instead of applying a ligature to the innominate, the axillary artery had been secured, the physiological demand for a blood-current through the aneurism being at the same time removed by amputation of the upper extremity, there would have been every reason to expect a successful result, without there being any risk of the secondary hemorrhage which almost inevitably follows the use of the proximal ligature in cases of this nature? If any operation at all is to be practised on the cardiac side of an aneurism involving the third and second parts of the subclavian artery, an attempt should, we think, be made to secure the obliteration of the vessel by the use of such an instrument as that devised by Dr. Speir, of New York; an instrument which, without endangering the integrity of the outer coat of the artery, severs its inner coats, and thus permits the occurrence of that retraction and contraction which are so essential in nature's method of accomplishing the desired object.

We next turn to an interesting account of a case of *Removal of a Needle from the Heart; Recovery of the Patient*; by George William Callender, F.R.S., etc. The patient, a man thirty-one years old, after a struggle in a tavern, missed a needle which he had placed in the left side of his coat, and nine days subsequently came under Mr. Callender's care, complaining of "beating" of the heart, and of constant pain extending from the left nipple towards the

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and is figured as such in Mr. Porter's paper, to which Mr. B. refers (*Dub. Quart. Journ. of Med. Sci.*, Nov. 1867, p. 275). Mr. Porter's own invention is figured in Mr. Stokes's paper on Temporary Deligation of the Aorta, in the number of the same Journal for August, 1869. Crampton's instrument, which modern inventors seem to have agreed to ignore altogether, is described and figured in the *Med.-Chir. Trans.*, vol. vii. (1816), p. 365.

axilla, and down the inner side of the arm as far as the elbow. This pain and a slight fulness and sense of resistance in the fifth intercostal space were the only symptoms present, but were deemed sufficient to warrant an exploratory incision, and, as soon as the skin and superficial fascia had been divided, the extremity of the needle was distinctly felt. The foreign body moved with each impulse of the heart, describing a double curve, and was thus evidently fixed in the heart itself near its apex. Removal was effected without any difficulty, and the patient made a satisfactory recovery, though he was kept in bed for several weeks as a matter of precaution. Mr. Callender appends a table of nineteen cases (twelve of which appear in Fischer's table copied in Holmes's *System of Surgery*, 2d ed., vol. ii. p. 602), in which needles or similar foreign bodies have been removed from, or found after death in, the heart or pericardium, and shows that in none is the evidence satisfactory as to the time during which the foreign body had actually been present in the heart. He hence infers that proof is as yet wanting that life can be prolonged for more than a few weeks after the entrance of such a foreign body into the organ in question, and claims that his own case is "the only instance on record in which a patient has recovered after the removal by a surgical operation of a needle from the heart."

A Case of Excision of the Knee-joint for Disease in a Woman fifty-three years of age, with successful result, is the subject of the next communication, which is contributed by FREDERICK JAMES GANT, F.R.C.S., etc. The patient who was the subject of this operation had suffered more or less continuously for twenty-three years from rheumatoid arthritis of the left knee, the limb at the end of that time being almost useless, with fibrous anchylosis and subluxation of the joint. An attack of phlegmonous erysipelas delayed but did not ultimately prevent convalescence after the operation, and five and a half months subsequently the patient was able to walk with the aid of a stick.

The next paper gives an account of a *Successful Case of Gastrotomy in Extra-uterine Pregnancy;* by LAWSON TAIT, F.R.C.S. Ed. and Eng., etc. The patient was 29 years old, and had been married two years. She ceased to menstruate about September, 1871, and from the middle of March until July 20th, 1872, felt distinct movements of the fœtus, a slight bloody discharge appearing at the latter date, and all movements ceasing from that time. When she came under Mr. Tait's care in September, 1872, the lower third of the abdomen was completely occupied by a tumour, which was more prominent on the left than on the right side, and at four points (two on each side) there were irregular movable nodules. The patient said that her size had gradually diminished during the last two months. The uterus was rather larger than in its normal condition, soft, and somewhat fixed; had an open cervix; and did not move with the tumour. By rectal exploration a hard semilunar ridge could be readily felt behind the uterus. No information could be gained by either abdominal or vaginal auscultation.

Gastrotomy, or as it should rather be called *Laparotomy*, was resorted to on Nov. 2d (nearly four months, therefore, after term), the peritoneal cavity being opened as in the operation of ovariotomy, when it was found that the roof of the sac joined the parietal peritoneum about three inches above the pubis. The sac having been opened with precautions against the escape of fluid into the cavity of the abdomen, the legs and trunk of the fœtus were readily extracted; but its head, which was deeply packed into the pelvis, and adherent, was removed with great difficulty, a considerable quantity of hair indeed remaining and being subsequently picked out during the gradual closing of the sac. The umbilical cord was divided about its middle, and the placental portion allowed to hang out of the wound. The placenta, which was attached to the posterior surfaces of the uterus and the left broad ligament, was not interfered with, and the cut edge of the sac was secured to the edges of the external wound by means of a continued suture, the upper half of the wound being then closed by deep silver sutures. The after-treatment consisted in the retention of a siphon in the pelvic cavity, and in frequently washing out the sac with a solution of sulphite of soda. Portions of placenta continued to come away until Nov. 29th, after which the wound gradually healed.

In a previous case in which Mr. Tait operated, the placenta was removed, and the patient died; the successful issue in the present instance he believes to have been due to the fact that, in accordance with Koeberle's recommendation, the placenta was allowed to remain, the peritoneal cavity closed, and the abnormal sac left open. Mr. Tait strongly advises that in similar cases an operation should be resorted to before the liquor amnii has been absorbed, and before, therefore, adhesions have been formed between the fœtus and the cyst. A chart is appended to Mr. Tait's paper showing the morning and evening temperature of his patient during the time occupied by the healing of the wound.

We next come to a paper *On Disseminated Suppuration of the Kidney, secondary to certain conditions of Urinary Disturbance;* by WM. HOWSHIP DICKINSON, M.D. Cantab., F.R.C.P., etc. In this paper Dr. Dickinson describes that peculiar condition of the kidney which has recently been so much talked about as the "surgical kidney," and which he believes to be produced by the contact of unhealthy and particularly of ammoniacal urine. A short notice of Dr. Dickinson's communication appeared in the number of this Journal for July, 1873, p. 251, and as in that notice the *clinical* features of the disease in question were chiefly referred to, we shall here direct our attention mainly to its *morbid anatomy*. The pathological appearances in this form of renal disease have been described by Rayer and Brodie, and references to it are to be found in the writings of Mr. Hawkins, Dr. Wilks, and others. Both kidneys are commonly affected, the pelves being dilated, and their mucous surfaces inflamed, often encrusted with phosphatic deposits, and sometimes in a sloughing condition. The cortex of the kidney is usually thinned, its capsule being thickened and abnormally adherent both to the gland structure and to the surrounding fat.

"The glandular condition nearly resembles . . . the renal manifestation of general pyæmia. The kidney becomes swollen and full of blood, much of which remains fluid after death, though some vessels contain clot evidently of antemortem origin. The tissue is variegated with blotches and streaks of intense injection; it is soft, friable, discoloured, and prone to decomposition. The cones usually display to the scrutinizing eye sharply defined white lines, which start from the tips of the mamillary processes in the pelvic cavity and pass into or through the cones in the direction of their striation. These streaks look like, what indeed they are, distended tubes, and are important witnesses of perverted action. Close to them swollen bloodvessels are often conspicuous. Next, or possibly without such evidences of chronic change as the swollen tubes give, appear small, softly defined, fawn-coloured patches which streak the cortex from cones to capsule, or take the shape of wedges with the base against the capsule, the point entering the medullary tissue. These are at first scarcely less hard though more friable than the natural substance of the organ. They are surrounded and intermingled with vascularity. As the disease progresses they become large, irregular, and confluent, soften in their centres into ordinary liquid pus, and finally take the shape of scattered abscesses, varying from mere points up to the size of peas or even larger. . . . . .

"Passing to detail, and taking the straight tubes first as the parts of the organ first affected, these as they converge upon their outlets are often strikingly dilated, apparently from the backward pressure of the retained urine . . . They are variously occupied by saline matter, purulent secretion, fibrin, or epithelial growth . . . The change does not extend to the convoluted tubes, which remain for the most part natural. The veins which appear to be next involved in the disease, are generally distended with blood. The straight veins of the cones often display in section a partial distension which is probably the result of coagulation which has occurred during life. The large veins of the cortex are often similarly filled, and it sometimes happens that the arteries which pass in companionship with them are likewise permanently occupied. As a general rule, however, the arteries are natural, as also are the Malpighian vessels. The venous position of the clot in the condition under consideration differs from the similar result of ordinary pyæmia, in that the obstruction there is essentially arterial. The third stage of the disease is the scattered suppuration which is the most obvious result of the complicated process. The disseminated abscesses, or regions of cellular infiltration, antecedent to abscesses, are intertubular, and have relation to the course of the veins. . . . The Malpighian bodies remain unaffected by the disease, though the adventitious corpuscular formation often collects abundantly outside them. . . . . .

"Taking the structural changes in their mutual relation, the dilatation of the tubular exits, the morbid occupation of the veins, and the general absence of signs of tubal inflammation, the nature of the process is clear. This disorder has its origin in the regurgitation of urine charged with morbid products. This, forced backwards by the retention general in these cases, distends or occupies the straight ducts. Thence by transudation, or similarly, it enters the neighbouring bloodvessels, and charges them with an infection resembling in its results that of pyæmia. This is distributed by the veins to the rest of the gland, sowing abscesses in their course, and ultimately causing constitutional symptoms analogous to those of pyæmia otherwise derived. The condition of the kidney may be described as one of pyæmia arising within itself."

Dr. Dickinson suggests the name *uriseptic* as applicable to this form of renal suppuration; as the disease appears to result from the retention of ammoniacal and putrid urine, he advises that an attempt should be made to restore the normal reaction of this fluid by the internal administration of mineral acids, and suggests in addition the employment of carbolic acid or other antiseptic by injection into the bladder. Two finely executed coloured plates accompany this paper and illustrate the microscopic appearances described in the text.

We shall next invite our readers' attention to an elaborate paper *On the Infective Product of Acute Inflammation;* by J. BURDON SANDERSON, M.D., F.R.S., etc. The purpose of this paper, as stated by its author, is to show, (1) that in all acute suppurative inflammations the exudation liquids exhibit poisonous or infective properties when introduced either into the circulation, the serous cavities, or the areolar tissue; (2) that these properties are manifested in two ways, viz., in the elevation of the bodily temperature and in the production of secondary inflammations; (3) that the increase in temperature results directly from the presence of the poisonous or infective agent in the blood; and (4) that the secondary inflammations may be acute or chronic, the former differing from the latter both in respect of duration and as regards their anatomical characters.

"The author arrives at no conclusion as to the nature of the substance to which the pyogenic property of exudation liquids is due. In the acute process, attended with pyrexia and the development of secondary inflammations of great intensity, there is evidence to show that we have to do with septic decomposition; not only in the fact that bacteria are present, both at the foci of inflammation and in the blood, but also in the perfect identity of the symptoms with those of septicæmia. It is not, however, as yet proved that in chronic infection the irritant is of the same nature; for, although there are all gradations between septicæmic infections of the most rapid development, and slow processes of tuberculosis, this gradation in itself affords no evidence that the two are dependent on the same material cause."

Dr. Sanderson divides his paper into three parts, in the *first* discussing the nature of the inflammatory process, with a view to the consideration of the mode in which a primary inflammation gives rise on the one hand to fever, and on the other to secondary inflammations; in the *second* giving an account of certain preliminary inquiries conducted by himself in the year 1867–68; and in the *third* describing experiments made by Dr. E. Klein and himself in 1872, and detailing the conclusions derived therefrom. Our space does not admit of our giving a complete analysis of Dr. Sanderson's very able paper, and indeed it is hardly necessary that we should do so, for much of what is here recapitulated is already familiar to American surgeons from the author's well-known essay on the process of inflammation, in the last edition of Holmes's *System of Surgery*, and from his equally well-known communication to the London Pathological Society, an abstract of which appeared in the number of this Journal for July, 1872, pp. 253–257; we shall therefore content ourselves with giving the conclusions which result from his more recent experiments, referring our readers to the original paper for full details of the experiments themselves.

"It has been shown," says Dr. Sanderson, "(1) that that combination of malignant fever with intense and destructive inflammation to which pathologists have rightly applied the term septicæmia, because it is known by experiment as well as by clinical observation to result from the existence in the blood of putrescent albuminous matter, may also be produced by the introduction, into the circulation or into the serous cavities, of small quantities of liquids derived directly from living tissues in certain states of inflammation; and that such states have the same distinctive characters as those which distinguish inflammation of septicæmic origin. (2) That pyæmia (the term being understood to denote a general febrile disorder of less virulence than that of septicæmia, accompanied by numerous disseminated inflammations, characterized chiefly by their proneness to suppuration) is so closely related to septicæmia as regards its origin and essential nature that in these respects no line of distinction can be drawn between them; and that pyæmia, like septicæmia, may originate from a purely traumatic inflammation, independently of any infection with contagium derived from a previously existing pyæmic inflammation. (3) That both of these conditions are characterized by the existence of microzymes in the infected liquids; and that the relation of intensity between different cases of septicæmia and pyæmic infection is indicated by the number and character of these organisms; so that in the most intense processes (*i. e.* those which exhibit the characters of septicæmia), the exudation liquids and the blood are crowded with actively moving bacteria, while in the more chronic processes, the spheroidal and dumb-bell forms prevail, and the numbers of organisms found in the liquids are relatively inconsiderable."

These microzymes Dr. Sanderson believes to originate from external sources, but, he adds:—

"Even if the extrinsic origin of microzymes were proved, it would afford no ground for concluding that the origin of the contagium itself is also extrinsic. It does not at all follow because these organisms come in from outside that they bring contagium along with them; for it may be readily admitted that they may serve as carriers of infection from diseased to healthy parts, or from diseased to healthy individuals, and yet be utterly devoid of any power of themselves originating the contagium they convey."

The last of the surgical papers contained in the present volume is a *Case of Abdominal Aneurism successfully treated by Proximal Pressure of the Aorta*; by EDWARD HEADLAM GREENHOW, M.D., F.R.S., etc. The essential features of this case, which was one of much interest, have been already laid before our readers in the number of this Journal for October, 1873, pp. 548–550.

J. A., JR.

We shall next invite attention to the medical papers in the volume. *On the Morbid Effect of Alcohol, as shown in Persons who trade in Liquor;* by WM. HOWSHIP DICKINSON.—This communication is very fully noticed in the January number of this Journal for last year.

On the Respiratory Movements in Man, with an Account of a new Instrument for measuring the Movements of the Chest; by ARTHUR RANSOME, M.D., etc.—The various modes of measuring the movements of the chest in use simply give either the gross enlargement of the circumference of the chest, or the resultant of the movements of its different parts, without estimating their extent in the upward, forward, and outward directions. To supply this want Dr. Ransome has invented a very ingenious instrument the description of which we will not transfer to these pages, because it would be unintelligible without the diagrams that accompany it. In regard to the order of movement of the ribs in inspiration, the author says his experiments have convinced him that the lower ribs are the first to move, and that the movements of the second ribs are less extensive that those of the fifth, as might have been expected from the greater length of the latter bone; but they are also much less acute, and more equable in their rise and fall, showing that the work done by the upper ribs is performed more gradually and that these remain at the point of extreme expansion rather longer than the lower ribs. The amount of movement varies in different cases, being greater in children than in adults. It will also vary with the position of the person undergoing examination, but there is not so much difference between men and women in the extent of movement of the upper part of the chest, especially upon forced breathing, as had been supposed. In a large proportion of the men examined, it was found the movements on the right side of the chest exceeded those on the left; in most of the women, on the contrary, the motions of the left side were greater than those of the right side. As a rule, the movements of respiration are much less extensive in disease than in health, except where one side has undergone an enlargement to compensate for loss of breathing room on the other. In some cases the movement upwards are exaggarated. Diminished motion will be observed in patients suffering from the following diseases: emphysema, asthma, phthisis, chronic bronchitis, and acute inflammations of the lungs and pleural membrane. The paper is illustrated by numerous diagrams.

Progressive Muscular Atrophy accompanied by Muscular Rigidity and Contraction of the Joints; communicated by SIR WILLIAM GULL, Bart., M.D., F.R.S.—The principal interest in this case is connected with the examination of the nervous centres, which was made by Dr. J. Lockhart Clarke. The changes in the brain seem to have been unimportant. The white substance was found interspersed with corpora amylacea, varying from about twice the diameter of a blood disk to fourteen times that size. A few of these bodies were also scattered throughout the gray substance, but they were confined chiefly to the deeper layers. The cells of the gray substance were not altogether healthy. Some of them had lost their natural sharpness of outline. Others contained rather more pigment than usual, or were somewhat granular at their surfaces. The pons Varolii, the medulla oblongata, and spinal cord were all notably diminished in size, and were the subjects of degenerative changes. Corpora amylacea were scattered thickly throughout the substance of the first two, particularly in the white substance. Moreover, the nuclei of the following nerves: the abducens and the facial, the trigeminus, the hypoglossal, the spinal accessory, and vagus, had undergone more or less pigmentary degeneration. The bloodvessels of the medulla oblongata were much dilated. In some instances they had wholly disappeared, leaving large empty and smooth walled tubular spaces. In the spinal cord, the gray substance from one end to the other was severely damaged by a variety of lesions and degenerations. In the upper cervical region on a level with the second and third pair of nerves, all the white columns were much congested; the connective tissue between their fibres was greatly hypertrophied. In the left lateral half of the gray substance a large triangular and somewhat transparent area of disintegration was found in the interior of the anterior cornu, leaving only a wall of healthy and darker tissue around it. This morbid area consisted only of small remnants of partially disintegrated gray substance, irregularly connected with one another, and forming together a kind of reticular or honey-comb structure. On the right side, a large area of transparent disintegration involved the whole outer half of the anterior cornu, and reached as far back as the projecting group of cells which Dr. Clarke has named the tractus intermedio-lateralis, and which is connected with the lower rootlets of the spinal accessory nerve. Extending into this track was a large hemorrhagic clot. Two other clots were formed in the neighbourhood of the first. Similar changes were discovered in the lower part of the cord, but we have not sufficient space at our command to particularize them.

The symptoms presented by the patient are very clearly explained by the morbid changes that were found in the medulla oblongata and spinal cord. The embarrassed articulation, the nasal character of the voice, the difficulty in swallowing, and the constant escape of saliva from the mouth, resemble the group of symptoms which constitutes glosso-labio-laryngeal paralysis, and are explained by the morbid changes found in the nuclei of the facial, hypoglossal, vagus and spinal accessory nerves. The great feebleness of the respiratory movements is accounted for by the lesions that were found in the anterior and lateral gray substance of the cervical and dorsal regions of the cord. The same progressive lesion of the anterior gray substances in the dorsal and lumbar regions of course explains the paralysis of the upper and lower extremities, and the decided sclerosis of the antero-lateral columns accounts for the stiffness and contraction of the joints.

A plate accompanies this paper.

The Pathology of Chronic Bright's Disease with contracted Kidney, with especial reference to the Theory of Arterio-Capillary Fibrosis; by George Johnson, M.D., F.R.S., etc.—Dr. Johnson's views of the nature of the changes in the form of Bright's disease characterized by contraction of the kidney are pretty generally known and were noticed in the 57th and 67th volumes of this Journal. We, therefore, propose at present to call attention only to those parts of his communication in which the opinions of Drs. Gull and Sutton, on the pathology of this disease (see April number of this Journal for 1873) are criticized. An examination of the specimens convinced Dr. Johnson, of the correctness of his first impression, that the hyaline fibroid appearance is not an indication of a pathological change occurring during life, but a *post-mortem* physical result of the imbibition of fluid by the coats of the vessels. He has never been able to detect the hyaline thickening of the external fibrous tunic in vessels examined immediately after removal from the body. It is almost always seen if the vessel, no matter what may have been the cause of death, has been immersed for some time in glycerine and camphor water, and is never seen if the preservative fluid employed be either spirit, or a solution of common salt of sp. gr. 1030. With regard to the physical conditions which favour the imbibition of fluid by the fibrous tunic of the arteries, he says, it is certain, the process is quickened by acidity of the fluid and prevented by its alkalinity. In his collection are specimens of normal arteries from the same subject, one set preserved in an acid fluid having the fibrous tunic distended and hyaline; the others, after being distended by the acid, have been made to shrink, and again assume the fibrous character by the addition of ammonia. He thinks it not unlikely that thickening of the fibrous tunic may sometimes occur in the vessel of the pia mater, as a result of *post-mortem* maceration in the subarachnoid fluid. The glycerine fluid, by distending the fibrous tunic, often presses the muscular coat more or less irregularly inwards so as to narrow the canal of the artery; frequently, too, he adds, it appears to fuse together the muscular elements, rendering them indistinct and giving the thickened wall of the artery a homogeneous or a granular appearance.

An Analysis of Ship Air and its Effects; by ALEXANDER RATTRAY, M.D., Edinburgh.—Many causes combine to render the air of ships more impure than that of houses or hammocks, and chief among them is overcrowding with deficient ventilation. While the soldier has at least 600 cubic feet of sleeping room, and from 1500 to 1800 in the tropics, the crew proper of a frigate really have no more than 63 in the densely crowded lower decks at meals, and from 105 to 222 at night on the sleeping decks. The amount of space allotted to the cadets and officers, although larger, is also insufficient for the requirements of respiration. The principal impurities which Dr. Rattray found in the air of ships were carbonic acid, sulphuretted hydrogen, ammonia, watery vapours, and organic matter. These are derived from the lungs and skin of the crew, from the ship itself, from the stores, from gun-firing, and from sea spray.

The evil results of being subjected to this unhealthy influence would be much more marked than they are, were it not that the sailor spends a great part of the day on deck, where he breathes the purest of all airs. To the bad effects of foul air of ships the author, however, attributes the low average age of seamen, and their predisposition to scrofula and phthisis. He, therefore, dwells upon the importance of securing for every vessel the best and most efficient means of ventilation. The paper is illustrated by a plate representing, 1st, fine dust from lower deck; 2d, living acari from lower deck, night air; 3d, small round and oval bodies in lower deck, night air; 4th, blood from erysipelatous leg containing animalcules.

A Second Report on the Communication of Syphilis in the Practice of Vaccination, with two additional cases; by JONATHAN HUTCHINSON, F.R.C.S.—A very full abstract of this interesting paper will be found in the number of this Journal for April, 1873.

On three Peculiar Cases of Molluscum Fibrosum in Children; by JOHN MURRAY, M.D., communicated by Thomas Smith, F.R.C.S.

Report of a Case of Molluscum Fibrosum or Fibroma, with Remarks; by GEORGE POLLOCK, F.R.C.S.

The three cases reported in the first of these papers are certainly peculiar as well as interesting, and were it not that Mr. Jonathan Hutchinson and Dr. Tilbury Fox agree with Dr. Murray in thinking that they belong to the same family group as molluscum fibrosum, we should have some difficulty in regarding them as really instances of this disease. The patients were all children, belonging to the same family, and having been subjected since their birth to the same unhealthy influences. Their parents were first cousins, but both were perfectly healthy, and had an unusually fair family history, being free from inherited or acquired syphilis. In each case the disease was first observed about the time the teeth were cut, manifesting itself primarily in the gums. In regard to the appearance of the gums, the author says, when speaking of the case in which the lesions were most marked: "They are everywhere greatly hypertrophied, and they almost completely bury the teeth. They form in parts numerous papillomatous or polypoid-looking growths, and in other situations present a peculiar fungating appearance; indeed, this latter characteristic of their growth is at once observed. . . . . The enlargement of the gums is most marked at their upper and free surface, where they are mostly flattened out, and in parts hardened by the pressure of the opposing gum. They present the natural colour, and, although they are in parts somewhat soft, vascular, and spongy looking, they mostly feel firm and fibrous to the touch." In the same case the fingers of both hands had undergone a very striking change. "With the exception of the forefinger of the left hand," the author says "the superficial soft structures, at least of the last phalanx of the fingers and nails, are greatly and curiously hypertrophied. The enlargement, density, and appearance of the affected fingers are not at all uniform. The extremity of the finger is much more increased in size in one part than another; the surface is smooth in parts, elsewhere rough and nodular. The smooth portions present here and there a cystic appearance, as if from dilated ducts filled with clear fluid, but on pricking them, blood alone, presenting no abnormal microscopical appearance, escapes, and is not followed by local collapse. The hard and irregular portions appear to be composed to a large extent of hypertrophied epidermic structures, which here and there may be peeled off." The toes were affected in the same way as the fingers, but to a much less extent. On other parts of the patient's body the changes more closely resembled those which characterize molluscum. On the forehead there were four tumours covered by skin, and varying in size from a small pea to a date. They are described as being smooth on the surface, firm, elastic, and pretty freely movable with the skin. They were not painful and apparently not tender to firm pressure. The periosteum beneath one of these growths felt slightly thickened. Similar tumours were situated on the lower aspect of the chin and the left cheek, near the border of the lower jaw. At the junction of the right ala of the nose with the cheek was a small and slightly raised, wart-like body, a *verruca plana*. In the same situation on the left side there was a commencing growth of a similar character. Both ears presented a curious appearance from the existence of prominent growths, chiefly on the anterior aspect of the helix. They numbered altogether about a dozen, and varied in size from a millet-seed to a bean. They were painless, and mostly hard, tough, and fibrous to the touch, and covered with pale, rough and in parts glistening skin. Some of those of the posterior aspect of the arm were softer, more elastic, of a bluish colour, and apparently more vascular, and this is also true of some of the tumours on other parts of the body. On the scalp were four cicatrices, the seat of former tumours, and in the skin of the neck, and in that covering the shoulders and buttocks, numerous white glistening flat elevations were observed. These resembled in appearance smooth warts, varying in size from a pin's head to a shirt button; they were in some instances isolated and distinctly circumscribed, but in others blended together in groups of about a dozen. Notwithstanding the extent of the disease, the patient's general health was excellent. She was, however, almost deaf, and was able to articulate only a few words, and those very indistinctly. In the opinion of the aural surgeons who examined her, the impairment of hearing depended upon a nervous lesion. Inasmuch as the appearances in the two younger children, aged respectively 3¾ and 2 years, did not differ materially from those detailed above, we shall not recapitulate them, but proceed at once to give the results of the microscopical examination of one of the tumours removed from the ear. After staining thin sections with carmine, Mr. Henry Arnott found that the epithelial surface was perfectly normal, and that the loose connective tissue supporting the *rete mucosum* was also in no respect different, either in form or in amount, from that usually met with in this position. Beneath this there was growth of firmer consistence. The bulk of this, constituting the new growth under investigation, was seen to consist of a homogeneous uniformly stained substance pervading the mass in irregularly waving broad tracks, which inclosed in their interstices smaller interlacing streaks of the same material, and numerous small cells entangled in this finer meshwork, the proportion of cells to the stroma tissue varying much in different parts of the same section. Certain portions of the tumour bore a close resemblance to cartilage, especially to the cartilage near to forming bone, where, as the result of rapid proliferation, many small cartilage cells are crowded into each enlarged space. From his examination, Mr. Arnott concludes that the tumour belongs to the connective tissue group, its histological elements being partly those of ordinary connective developing into fibrous tissue, and partly those of cartilage.

The author brings his paper to a close with a few remarks in regard to the probable cause of the disease in the three cases. "There are," he says, "two possible factors—either the bad hygienic condition under which the children were born and exposed after birth, or the parental consanguinity, or perhaps both. The eldest child of the family was a fine boy 10 years old, who was born and lived for eighteen months in a comparatively healthy first floor; the three others were born on the ground-floor of the same house; there being no kitchen or cellar beneath the sleeping apartment, which was, according to the positive statements of the parents, excessively and sensibly damp, so that the mattress on which they slept became mouldy. It is at least singular that the three younger members of the family who were all subjected *from birth* to the influence of damp for varying times, were all affected, and the disease was marked in them in a degree corresponding very much with the duration of the exposure. On the other hand, the disease progressed in all the affected children for a long time after they had been removed from the influences in question. Shortly after the paper was read, the mother was delivered of another child, who was perfectly healthy in appearance, except that there were numerous blotches (nævi materni) of a bluish colour, chiefly on the scalp and face."

A coloured plate showing the changes in the gums and fingers accompanies this paper.

Mr. Pollock's patient had, as far back as she could recollect, always been the subject of molluscum fibrosum. The growths had, however, not only increased in size since her childhood, but had also become more numerous. The photograph which is appended to this paper, shows that the tumours occupied various positions. There were three large ones, the rest, more than one hundred in number, varied in size from a small walnut to that of a split pea or even something less. One of the large ones was attached at the back of the head to the scalp and neck on the right side chiefly, and its size was about that of a small mellon. A second growth was connected with the top of the right shoulder. The most remarkable and largest of the tumours was in front. This grew from the right side of the neck, and extended in the shape of a long, thick, and broad pendulous flap of skin to below the level of the navel by an inch or two. The general colour of the skin covering this mass was darker than that of the rest of the body. It was pretty uniformly marked by the orifices of obstructed sebaceous follicles, the contents of which could be pressed out to some length. In a large portion of the mass sensation was impaired. Dr. Whipham, who made a microscopic examination of one of the tumours, reports as follows:—

"The growth, therefore, is due partly to an excessive hypertrophy of the connective tissue of the true skin, and partly to an abundant cell-growth occupying interspaces between the bands of fibrous and elastic tissue, which, as has been shown, composed the chief part of the growth. Neither the large pendulous, nor the smaller sessile tumours depend upon any alteration in the epidermis, rete mucosum, glands, or hair bulbs, as far as can be made out."

The large mass was removed by an operation, and was found to weigh 2 lbs. 6 oz. The patient made a good recovery.

The Pathology of Leprosy; with a note on the Segregation of Lepers in India; by H. V. CARTER, M.D.—The destruction of the cutaneous nerves is regarded by Dr. Carter as the characteristic lesion of leprosy; the alterations of the skin, no matter what their nature may be, being secondary to this. Moreover, he believes the manifestations of the disease are limited to the cutaneous system, saying that in those cases in which the inguinal glands, the nipples, and the testes are observed to be enlarged, inquiry will show that these changes are referable to a syphilitic contamination. The lesions which are really caused by leprosy are "due to exudation or deposit in the skin and nerve-trunks of a firm, translucent, colourless or pale reddish material, which may be distinguished by the borrowed terms 'hyalin-fibroid' and 'hyalin-granular.'" As regards the nerves, this deposit first appears between the individual nerve-tubules and within their common envelope, *i. e.*, the neurilemma of the funiculus; the outer sheath of connective tissue is hardly changed. By accumulation of the new material, the nerve tubes are separated, compressed, and eventually destroyed. The microscopic characters of the leprous deposit, the author continues, favour the view of its being an exudation capable of a low grade of development. At a subsequent stage, fatty or even calcareous degeneration may take place. So extensive is this affection of the cutaneous nerves, that Dr. Carter believes that it may in time involve them all.

He was in no case able to detect any constriction at the point where the nerves pass through the fascia to become cutaneous, which could account for the limitation of the disease. Sooner or later some of the deeper-seated main nerve trunks of compound function become more or less diseased, but the nerves which most frequently suffer, are the ulnar at the elbow and wrist, the popliteal in the ham, the posterior tibial at the ankle, or, in other words, at points where they are most superficial and therefore most likely to be reached by some irritative influence. It is to be noted that not every part of the larger trunks in these instances is impaired, since motor paralysis is rarely present to any extent, even in the worst cases of leprosy. The inferences which the author draws from this are that the sensory element of these compound nerves is alone implicated, and that trophic nerve tubules are commonly associated with those termed sensory.

Dr. Carter looks upon leprosy as a constitutional affection transmissible from parent to child, the tendency to which, however, in a person predisposed being increased by all causes leading to deterioration of health. He does not think that the disease has been proved to be contagious, or that it has been traced to endemic influences. Believing, therefore, that heredity is the common cause of the complaint, he argues that strict segregation of all lepers is the only way effectually to "stamp it out."

A plate showing the microscopic character of the morbid deposit in leprosy is appended to this paper.

On the Elevated Health Resorts of the Southern Hemisphere with Special Reference to South Africa; by E. SYMES THOMPSON, M.D., F.R.C.P., etc. etc. —We shall make no attempt to analyze this paper, which consists mainly of an enumeration of places in Africa, India, Australia, New Zealand, and South America, having claims to be considered "Health Resorts," since Dr. Thompson gives us very little information in regard to either the peculiarities of the climates of these places, or the class of patients it would be proper to send to them.

Preternatural Cavities in the Brain of the Sane and the Insane; by ROBERT BOYD, M.D., F.R.C.P.—Dr. Boyd, in the course of his investigations into the comparative frequency of tumours of the brain in the sane and the insane, was struck with the much greater frequency of an opposite condition, a partial atrophy, in the form of cavities, cysts, and depressions especially in the latter class. Thus these alterations were found in about 40 per 1000 of the sane, and in 47 per 1000 of the insane; whereas tumours of the brain were found in only 18.3 per 1000 of the sane and 16 per 1000 of the insane. A table containing 68 examples of the various forms of cysts is appended to this paper. In regard to the relative frequency of the different forms of cysts, we find that old apoplectic cysts distinguished by permanent blood staining from peroxide of iron were most numerous. Next in number to these were old serous cysts containing clear fluid and without discoloration, often accompanied by cerebral softening and most commonly met with in the insane. Next in order were small porous cavities, from the arrest and cure of ramollissement, all of them occurring in the insane. In two cases, in which there was no mental derangement, encysted abscess of the brain was discovered at the *post-mortem* examination.

Analysis of the Temperature, Pulse, and Respiration in Phthisis and Acute Tuberculization of the Lungs; by WILSON FOX, M.D., F.R.S., etc.—The observations on which this analysis is founded were made in the wards of University College Hospital upon eighty cases of phthisis, occurring, with but few exceptions, in adults who were admitted on account of the acuteness of the disease, its extent, or recent aggravation, and who were discharged, when it did not end fatally, as soon as the more urgent symptoms were alleviated. The disease was also more or less distinctly advanced, and the observations represent, therefore, the symptoms of a group of severe cases, and thus afford no information respecting the earlier stages or periods of comparative quiescence. For the sake of convenience, Dr. Fox divides his cases as follows: 1. Fatal cases. *a.* Acute tuberculosis; *b.* Acute phthisis; *c.* Chronic phthisis. 2. Non-fatal cases. *a.* With high temperature; *b.* With comparatively low temperature. The facts analyzed in the different classes relate chiefly to the following subjects: 1. The maximum temperature observed. 2. The averages of the morning and evening temperatures. 3. The frequency of normal or subnormal morning and evening temperatures. 4. The comparison of the temperature of the morning and evening. 5. The remissions and exacerbations occurring from evening to morning and from morning to evening. 6. Circumstances influencing the pyrexia. The higest ranges of temperature were observed, as a rule, in cases of acute tuberculosis, but the author found that temperatures exceeding 104° occurred in every class except in that in which are grouped cases of low temperature not ending fatally. The maximum temperature which he met with was 106.7°, but it was recorded on only one occasion in a case of acute phthisis. In all the fatal cases, with the exception of eight, the temperatures were higher than in the non-fatal, but a lower range of temperature existed in the cases of chronic phthisis than in the other fatal cases. The occasional exacerbations of fever occurring in the course of chronic phthisis are generally due to the extension, by inflammation, of the pneumonic process. In this way there is often an approximation of the temperature range to that observed in the more acute forms. In many of the cases of chronic phthisis a temperature exceeding 102° was observed. The cases included in the class of "high temperatures not ending fatally, " all presented a pneumonic attack supervening on pre-existing phthisis. Their average temperatures were lower than in the other acute cases, owing to the improvement in the symptoms and the subsidence of the pyrexia which took place as the result of treatment. The averages of both the morning and evening temperature in cases of "low temperatures" was, of course, below that of any of the other classes, rarely exceeding 100°. In the other classes there was a large number both of morning and evening averages of over 101°. Certain cases are, however, comprised in every class in which the mean of the whole series of morning temperature may be found to be within normal limits. The same fact has also been observed in regard to the evening temperatures, but with comparative rarity, except in the class of the "low temperatures." Morning temperatures, with an average within the normal, were not observed in any of Dr. Fox's cases of acute tuberculosis, but have been met with by others. Averages of the evening temperatures not exceeding 99° were met with by Dr. Fox only in cases of chronic phthisis and the class of "low temperatures." They have, however, occasionally been recorded in cases of acute tuberculosis. In one of the cases of "low temperatures" there was a complete inversion of the regular order, the morning temperature being always higher than in the evening. In this instance and in a few other instances the remission occurred between the morning and evening and not between the evening and morning. The maximum temperatures were usually attained in the evenings, and therefore the average temperature is in the majority higher for the evening than for the morning. In ten per cent. of the cases, however, the maximum temperatures observed in the morning and evening were equal, and in two of these the averages of the morning temperatures observed throughout the case were higher than those of the evening. In nineteen more, or 23.7 per cent., the maximum morning temperature was higher than the maximum evening observed, and in 15 per cent. the means of the morning temperature were higher than those of the evening. It is in the class of "low temperatures" that the higher morning temperatures are more frequently observed. Dr. Fox thinks it not unlikely that in some cases, when the morning temperature exceeds that of the succeeding evening, this may occasionally be due to a midday exacerbation; but inasmuch as very few observations were made by him at noon, he is unable to make an accurate analysis of this point. This explanation is not, however, applicable to those cases in which the morning temperature is higher than that of the preceding evening, and in which a true inversion of the order of exacerbations appears to take place. In a large proportion of cases of phthisis the temperature of the morning, when febrile, is occasionally found to equal that either of the preceding or following evening, and this equality is also observed within the normal range in cases with low degrees of pyrexia, but it is seldom maintained for more than a day. This equality of temperatures in the mornings and evenings, especially when long continued, is therefore generally associated with high pyrexia and with a severe form of the disease. Dr. Fox does not agree, however, with Niemeyer in thinking it more commonly met with in cases of acute tuberculosis than in any of the varieties of phthisis. Remissions occurred in every class. Marked remissions sometimes succeed exacerbations, but they necessarily follow one another, as a continuous or quasi-continuous temperature appears in some cases to be maintained, though generally only during short periods. The maxima recorded in these cases are a remission of 8.8°, and an exacerbation of 8.4°, which immediately succeed one another. Eight cases out of a total of seventy-five, or ten per cent., exhibited in their course remissions exceeding 5°; and five, or 6.6 per cent., had exacerbations of corresponding extent. These eight cases were divided as follows: Acute tuberculosis, 1; acute phthisis, 3; chronic phthisis, 2; high temperatures, 1; low temperatures, 1. With these exceptions the larger remissions and exacerbations were nearly equally distributed between the fatal cases of acute tuberculosis, acute and chronic phthisis, and the cases of high temperatures. They also occur in the class of low temperatures not ending fatally, but to a much smaller extent. From this Dr. Fox concludes, with Wünderlich, that from a thermometric point of view there is no feature which can be relied upon as a characteristic to distinguish acute tuberculosis from acute phthisis.

In regard to the cause of the variations of temperature, Dr. Fox says, this is in the majority of instances by no means distinct. He has more frequently than the reverse failed to find any positive evidence of increase of the physical signs following severe exacerbations. In many cases, however, they precede distinct and fresh pneumonic consolidations. In others they are due to rapid and extensive softening, or to intercurrent inflammation. Dr. Ringer was disposed to regard the severity of the fever as the measure of the process of tuberculization, but some cases of acute tuberculosis appear to form exceptions to this position. Pleurisy complicating phthisis may be attended by an elevation of temperature, especially when the effused fluid becomes purulent, but this is not constant; on the other hand, suffocative bronchitis and lardaceous disease of the viscera have generally a tendency to depress the temperature. Marked remissions are produced by diarrhœa, and perforation of the intestines has been observed to be followed by a fall of temperature amounting to collapse. The author has not found that hæmoptysis, even when the amount of this is considerable, exerts any influence on the reduction of temperature, and it is not followed constantly, in his experience, by the exacerbation to which attention was called by Niemeyer. Perspiration appears to be the consequence rather than the cause of the fall in temperature. As in other diseases, the patient's sensations are no guide as to the degree of fever present. The frequency of the pulse bears generally a definite relation to the intensity of the disease, but even in fatal cases it occasionally falls to less than 70° both in the morning and evening. The larger number of the quickest pulses occurs in the morning, which so far confirms Dr. E. Smith's observation, that the rate of the pulse falls after 9 P. M., and rises in the morning. The respiration is also accelerated, usually, also, in proportion to the intensity of the disease; but even in non-fatal cases a considerable number present a mean both of morning and evening respiration above thirty in the minute. No constant ratio can be established between the pulse and temperature, yet cases distinguished by rapidity of pulse are most commonly those where the temperature is highest, and conversely uniformly low pulses exist with low temperatures. Increase of temperature is observed in the evening in a larger proportion of cases than increase of pulse. The relation of the respiration to the pulse is more definite than it is to the temperature, though here also great variations may be observed. Quick breathing may be associated with a slow pulse, and, what is more common, slow breathing, with a rapid pulse. Thus, the ratio, when the breathing is very rapid, may be absolutely reversed, as pulse 72, respiration 78; pulse 76, respiration 96. A very frequent pulse may, on the other hand, increase the ratio of the pulse to the respirations by more than 6 to 1; but this may also exist to a considerable degree when, without a very rapid pulse, the respiration is proportionately retarded, and may even be observed in acute tuberculosis. The pulse respiration ratio is, on the whole, the author thinks, very little influenced by the temperature, though a ratio of the pulse to the respiration of less than 2 to 1 is most common in the "low temperatures," inasmuch as the pulse is more influenced by the temperature than the breathing. In individual cases also great variations may be noticed on different days in the relations of the pulse and respiration. The paper is a very valuable one, and it is evident that Dr. Fox has taken great pains to make it so. An appendix contains twenty-two tables, wherein the points to which we have alluded in the foregoing notice are very fully analyzed. J. H. H.

Art. XVIII.—*Saint Bartholomew's Hospital Reports.* Edited by Dr. Andrew and Mr. Callender. Vol. IX. 8vo. pp. xliv., 258; x., 81. London: Longmans, Green, & Co., 1873.

This volume, which (as we learn by a prefatory note) completes the first series of the *Saint Bartholomew's Hospital Reports*, contains, in addition to seventeen distinct articles of scientific interest, short biographical notices of four deceased officers of St. Bartholomew's Medical College, viz., the brothers William and Edward Ormerod, Frederick Carpenter Skey, and Holmes Coote. The sketches of the Ormerods are from the pen of Sir James Paget, who is perhaps likewise the writer of Skey's and Coote's memoirs, though these are published anonymously. All are well done and full of interest, candid and yet appreciative—models in our judgment of what necrological notices should be. The chief lesson to be learned from the lives of the Ormerods is the value of a strong sense of duty; as their biographer happily expresses it—

> "They were very dutiful. Whatever came to be their duty, whether through choice or circumstance, they did it with all their might. Learning or teaching, practice among the poor or among the rich, work for the present or for the future—if it was duty, it was done. And they did not go far away, or take much thought, to find where or what was their duty. It was always at hand, in the common business of their calling, or if beyond this, in the nearest and best work for which they could fairly, or even modestly, think themselves fit. From their devotion to duty, more than from anything else, came their success."

William Ormerod died when 42 years of age, Edward when 54, and Holmes Coote when 55—Skey alone living to complete his threescore years and ten.

Of the papers devoted to scientific subjects, eight may be classed as surgical and seven as medical, the remainder consisting of the Proceedings of the Abernethian Society for the college year and the Hospital Statistics. Taking up first the surgical portion, we shall now invite our reader's attention to a somewhat lengthy paper, entitled, *Two Years of Hospital Practice*; by George W. Callender, F.R.S. Many of Mr. Callender's cases are of interest, and his success in treatment has been very great—greater, we venture to think, than he will be likely to find it, should he continue his statistics through a long term of years. The mode of dressing wounds employed by Mr. Callender is already known to our readers from his paper in the sixth volume of the Clinical Society's Transactions, noticed in the number of this Journal for April, 1874 (p. 458). Since the date of Mr. C.'s last published account of his practice, in the fifth volume of the *St. Bartholomew's Hospital Reports* (see No. of this Journal for Jan. 1870, p. 196), Sir James Paget and himself have performed thirty amputations, including twenty-six of the lower extremity, and Mr. Callender has treated conservatively twenty-two cases of compound fracture, including fifteen of the lower extremity, every case in both categories having terminated in recovery. As a contribution toward settling the controversy now in progress among our New York friends, as to the possibility of curing fractured thighs without shortening, we note with interest Mr. Callender's measurements in twenty cases, only four of which gave no shortening—two of these being in children aged five and seven years respectively, and one being a